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WITH THE REPORT OF A CASE.

A Paper read before the Academy of Medicine, November 10, 1890,

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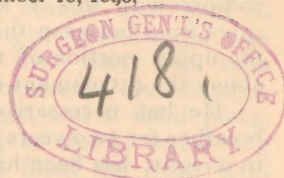
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Mr. President and Gentlemen:

I merely wish this evening to call your attention to a case that recently came under my care; I have no new theories to advance, no original methods of operating, no special arguments to bring forth, and, considering their great unreliability, I have no statistics to present to you; therefore, I beg your indulgence while I confine myself to a report in detail, both as to the history of the case and of the operation.

Frank ———, aged nineteen years; well developed; nose exceedingly large; habits good; general health apparently much impaired.

His trouble dates back to 1882, when he complained of very frequent colds, with the resulting stuffy feeling of both nostrils, lasting for several days.

He consulted his family physician frequently during a period of several months, but he gradually grew worse, especially during the winter months. He consulted Homœopaths, Eclectics, Christian-Science quacks, and Faith-Healers, but at no time did he undergo an examination to reveal the cause of his trouble; that he had nasal catarrh was all that he could elicit from those in attendance, and treatment availed naught.

In 1886 he came to Cincinnati, and, after reading the daily papers, especially the advertising columns, at once

consulted the person having the most conspicuous "catarrh ad." He was a frequent caller at this office for nearly five years, or until I saw him a few weeks ago, and has undergone the so-called absorption treatment by means of spray solutions.

No examination of the anterior or posterior nares had been made during all of this time, according to the patient's own statement. However, just before I saw him, while seated for treatment he happened to open his mouth, and as he did so the doctor discovered a mass hanging below the velum palatæ fully one-half inch. Now I say, *happened* to open his mouth; that is exactly the expression, for during all of the preceding treatment the doctor had not requested such a thing. Two unsuccessful attempts of three and two hours' duration respectively were made at removal with the snare through the mouth—no attempt having been made to remove the tumor situated in the anterior nares.

After these failures the only recourse allowed the patient was to submit, while under general anæsthesia, to one of the many operations devised for its removal externally, viz., by cutting down through the nose, pulling down the flap, and then extirpating, as best determined by the operator.

For three years he has never been able to blow his nose well, and during

the past two years has been unable to force air through the nostrils, although barely able to obtain a little air upon very deep inspiration. Whenever he would blow hard, there would be a distinct valve-like click at once, and immediately would follow complete closure of both nares. Watery discharge was abundant, and frequently associated with it were white flakes of a cheesy *débris*, that seemed to have been firmly compressed; this I afterwards found came from between the tumor mass and the upper portion of the septum wall, above the attachment of the tumor.

He has necessarily been a mouth-breather for two years; has lost steadily in weight; has been having quite severe and frequent asthmatic attacks, as many as six in a single night; he has had a troublesome cough. For some months he has been trying vainly to swallow something, so he stated, this was the lower portion of the tumor hanging through the naso-pharynx. Headache has been persistent of late, but confined entirely to that side of the head from which the tumor originated, extending throughout the right supra-orbital and right parietal regions; headache had never been present before during the patient's life.

Epistaxis formerly was frequent, but never so severe as to cause any alarming symptoms; as the tumor increased in size, and especially as the nares became entirely occluded, this symptom became less frequent and less severe.

There was no exophthalmos; but slight impairment of vision on that side; sense of smell entirely absent; deformity slight on right side; nasal ridge nearly straight; right alæ bulged, yet there was not present a characteristic frog face.

Anterior Rhinoscopic Inspection.—

Left anterior nares completely occluded, not by any tumor growth, however, but a great deflection of the septum to the left throughout its cartilaginous and bony parts; the mucous membrane was intensely reddened and hypersensitive to the touch. I found the right nares entirely filled by a growth extending forward almost to the meatus,

and could readily be seen by tilting the point of the nose back a little without the insertion of a speculum; my view was obstructed in all directions. This

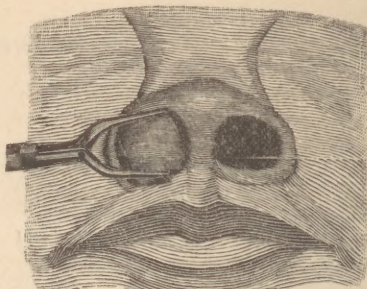


FIG. 1.—Shows the tumor as it appeared in the right anterior nasal chamber.

mass was of a grayish red in color, and upon introducing my finger against it found it to be quite firm and resistant, and its surface contained here and there strawberry-like indentations. Upon firm pressure with the finger or probe bleeding was free, but this I stopped by compressing the alæ together.

Posterior Rhinoscopic Inspection.—

I found an elongated uvula; soft palate pushed downward and forward; also a tumor mass in plain view, hanging one-

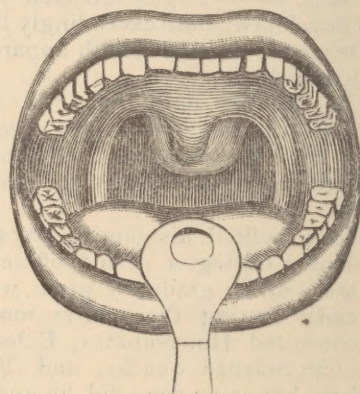


FIG. 2.—Tumor seen projecting from the post-nasal chamber, forcing the soft palate and uvula downward and forward, and extending below the uvula fully one-half inch.

half inch below the uvula. The nasopharyngeal space was completely filled by this tumor, which was less red than was that seen in the anterior chamber.

I here again used my index finger, and it was evident that the tumor was firmly wedged in, for it was barely movable; in fact, I made a third examination to assure myself of this fact. This immovability and firmness I thought perhaps was due rather to the wedging in of the tumor than to the texture of the tumor itself; and yet here, as before, I had free hemorrhage upon slight manipulation, so I was not willing to eliminate fibromata from my diagnosis.

I might here say that I suspected that the first tumor was cartilaginous—not a true cartilaginous one, but perhaps a fibro-cartilaginous one.

My diagnosis could not be positive without a microscopic examination, so I deferred that and sought to choose the best method of removal, the patient having given his consent, and having also given me freedom to operate as I wished.

From the reaction that followed each previous examination—pain in the ear, head, eye and face—it seemed to me that certainly that method that would produce the least irritation and subsequent inflammation would be the best. In a few cases reported other methods had been given up for the cold snare, but to my knowledge no failure has been reported following the latter method.

Roe, in 1885, reports an almost fatal hemorrhage following the use of the galvano-cautery snare, and the operation was finished with a Jarvis snare, without hemorrhage, by cutting through the mass very slowly; this operation was for the removal of a very vascular tumor of the nares.

This, perhaps more than anything else, led me to adopt, or rather not to adopt, the galvano-cautery wire. So I decided to use the cold wire snare, as first done by Jarvis about ten years ago. I concluded to clear out the anterior chamber first; by doing this, if I were to have a severe hemorrhage, as I expected, the posterior tumor so firmly wedged in would serve admirably as a plug, and thus lessen the danger necessarily entailed in any operation for complete removal.

First Operation.—Both anterior nares were thoroughly cleansed with a compressed-air spray of Dobbell's solution followed by cotton swabbing, and it was really astonishing the amount of *débris* removed. This done, I applied a 20 per cent. solution of hydrochlorate of cocaine, first as a spray, then with a cotton applicator. I waited ten minutes and passed the loop of a No. 5 piano wire over as much of the tumor as possible, and spent almost an hour in cutting it through; hemorrhage was considerable at first, but was soon checked with hot water and cocaine. I removed a second and a third piece, in all amounting in size to that of the largest olive. I filled the nares with powdered boracic acid and then saw him every other day. On the sixth day I cleansed as before, and removed a very large lobulated polypus, in seventeen lobules closely squeezed together, having a very broad base, and also growing from the same attachment as the tumor removed, and apparently as the posterior tumor. Hemorrhage was only slight during this sitting, which lasted for two and one-half hours. Three days later I removed two separate polypi hanging from the superior turbinated bone.

Second Operation.—Upon his return, September 10, the inflammation had subsided, and the anterior nasal chamber of that side was enormously enlarged; the lower and middle turbinated bones were entirely gone, there being scarcely enough ridge left to outline their former position.

I now attempted to pass a Eustachian catheter, through either nostril by the posterior tumor into the nasopharynx, hoping in this way to carry my loop below the tumor and thus engage it; I was unsuccessful in doing this, owing to the firmness by which the tumor was wedged in the nasopharynx; however, I did succeed in passing a loop from a Sajous snare through the mouth and over a small portion of the tumor, having an assistant to hold my laryngeal mirror and tongue depressor in place for me; I manipulated the loop as best I could with a silver Eustachian catheter, bent

as required. Over this snare, which had been well tightened, I now passed an extra heavy Bosworth snare, armed with No. 5 piano wire, and was able to pass this loop high enough to catch one-half the mass. I now removed the first snare and employed slow and cautious traction; at the end of four hours my snare was bent double and useless, so I cut the wire, released my hold, and, fearing hemorrhage, I passed an Aveling coil over the ends of the wire still *in situ*; I constricted this mass for an hour longer, removed the wire and allowed the constricted mass to slough, which it had done completely on the fourth day. I ordered frequent antiseptic washes of Listerine and permanganate of potash to overcome the odor arising from this condition.

So far the operation had been a bloodless one, as only a few drops of blood had been lost as the snare was brought home, this being the amount in the constricted mass.

Third Operation.—I passed a loop of No. 5 piano wire through the mouth and over as much of the remaining portion of the tumor as possible by means of an index finger in the nasopharynx. I again employed slow and cautious traction, and at the end of two and one-half hours again found my snare bent as before and unable to cut entirely through; so, after allowing this to remain awhile longer, I removed it and waited for the slough to come away, in the meantime using antiseptic sprays.

During this operation I allowed the patient to turn the milled nut of the écraseur himself, and at his own will. Pain was but slight and hemorrhage absolutely *nil*.

Fourth Operation.—At the end of another week I found that I was unable to engage any more of the tumor by way of the mouth, so, after satisfying myself that the attachment was not in the naso-pharynx, I passed the loop down through the anterior nares, and, with my right index finger in the nasopharynx, succeeded in catching the tumor firmly, and then drew it up as best I could into the anterior chamber;

the distance, however, was very slight, but I managed to pass the second snare over the first already attached, and, acting as before, removed a second piece, which was cut off quite close to the floor and septum wall to which it was attached.

These last two cuttings were made much more rapidly than any of the preceding ones, and as a result I had some hemorrhage; this, however, was readily controlled with pressure and hot water, and cocaine. I could now see quite well the field of operation, and this is what caused me to cut through so much more rapidly than I had previously done.

The removal now seemed complete, so I thoroughly cauterized the attachment surface with chromic acid and then allowed time for complete cessation of the inflammatory conditions excited. At the end of ten days I finished my examination, and found almost complete absence of the lower and middle turbinated bones on the right side, and, of course, a great deformity of the anterior and posterior nasal chambers and of the entire septum.

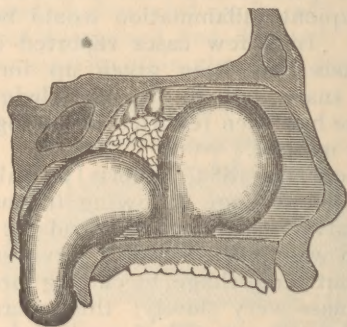


FIG. 3.—Shows the tumor and its extensive attachment; the right ala and right superior maxillary bone removed antero-posteriorly; posterior portion projecting into and beyond the naso-pharynx; polypoid mass above but having the same attachment, excepting three smaller ones, which were attached to the superior turbinated bone.

The tumor was a lobulated mass, having a very broad attachment to the floor of the nares, wall of the septum, and under surface of the lower turbinated bone, just forward of the union of the hard and soft palates; between the anterior and posterior masses, and

from the same attachment, was this mass of polypi; really, however, it was one immense polypus having many lobules. Only three small polypi were attached to the superior turbinated body.

I was very much surprised at the combined size of the pieces removed, and thought that surely the antrum of Highmore was invaded, but I failed to find this condition present; I also expected to find cartilage cells upon microscopic examination of the anterior tumor, but failed; the microscopic examination of both masses by myself and by experts revealed fibrous tissue in abundance, with here and there papillomatous changes; therefore, I have no hesitation in calling this a fibropapilloma.

It is unnecessary for me to state the great improvement of my patient's condition that has resulted so far, other than that he now enjoys free nasal breathing, his cough and asthmatic attacks have ceased entirely, his general condition is excellent, he having much more than regained his loss in weight, now weighing more than he ever did.

As to recurrence, owing to the short space of time that has elapsed since the final operation, I have no right to say other than my opinion, which is that I do not expect a recurrence. The tumor is thoroughly removed to a level with the surrounding tissue surface.

Owing to the great deflection of the septum to the left side, an operation to restore it to the median line will be made later. I hope to make a subsequent report of this case.

The interesting points in connection with this case are the following:

1. The comparative great rarity of this form of tumor in the anterior nares.
2. The place of and extensive attachment.
3. The intimate association of mucous polypi with this tumor.
4. The absence of great external deformity, considering the size of the tumor.
5. The method of removal, which allowed the operation through the mouth to be bloodless.

6. The rapid improvement of the patient's general condition.

DISCUSSION.

DR. ERIC SATTLER thought the case reported by the essayist unique, as well as interesting. A fibroma is one of the rarest forms of tumor in the anterior nares, although it is comparatively frequent in the naso-pharynx. Up to 1888 or 1889, only forty-one cases of fibromata have been reported as having been found in the anterior nares. All the cases presented some features resembling the case reported.

Very frequently nasal polypi are operated upon in a barbarous way, being simply torn out, and years after the patient has a fibroma of the nares.

Another peculiarity of this case is the fact that with so large a tumor in the anterior nares, the patient never felt that he had anything wrong in his throat. This tumor was eight years in growing, and it is strange that the patient did not have more symptoms pointing to the presence of this enormous mass. The deflection of the septum referred to was doubtless due to the pushing of the tumor to one side.

The origin of this tumor is rather rare. Fibromata rarely spring from the floor of the nose and the lower turbinated bone. The speaker took exception, also, to the title of the paper, as he thought it deceiving. These tumors could hardly be classed with the vascular tumors of the nares. There was not mentioned in the history any occurrence of epistaxis which is so frequent and dangerous a symptom in these tumors. The speaker, when he heard the subject announced, had expected to hear the report of an anginoma, or some tumor of this class. He thought the essayist's treatment of the case had been judicious, as well as successful. Another method which has given good results is electrolysis. Lincoln has reported cases in which the size of the tumor was greatly reduced by this means, and the same has been reported by others. The cold snare, no doubt, is the best means of removing these growths.

DR. T. V. FITZPATRICK, speaking of

the diagnosis of this case, remarked that we rarely find myxomata growing in this region; that we more frequently find here the papilloma. Myxomata usually spring from the middle turbinated bones. Bosworth reports about twelve deaths from hemorrhage after operation for removal of fibromata. He therefore thought that the essayist had properly consumed a great amount of time in treating this case.

The speaker then referred to a case which he had operated on, in which he had used the cold snare. Three-quarters of an hour were consumed without much progress, when he grasped the snare, and by main force succeeded in removing the entire growth. At a subsequent sitting he removed a larger tumor of the same kind. He did not wonder that the presence of the tumor had not been recognized by the patient, for we frequently see individuals who have large numbers of polypi in the nose and are not aware of more than a slight obstruction of the nostrils.

The method of electrolysis as used by Dr. Lincoln is a very interesting one. He found that by the use of zinc electrodes he had much greater effect on the tumor than by the use of gold electrodes. The method of Ingalls, by the galvano-cautery knife, is also an excellent one.

DR. JOSEPH RANSOHOFF did not see why specialists should divide into a separate class these tumors which drop into the anterior nares, fill up the whole of the nasal cavity and then drop back into the naso-pharynx. These tumors are much more frequent in males, as in this case. These tumors spring from the floor of the nares, and from the side of the inferior turbinated bones, as described in this case. Their point of origin is, however, as far removed from the anterior nares as it is from the posterior nares. They grow forward into the anterior nares and plug up the nostril, so that they can be seen when the head is thrown back, without the use of a speculum. They push upward into the antrum of Highmore and outward, separating the maxillary bones, so as to give us the "frog face," or backward into the naso-pharynx. There

is one thing unusual in this tumor, namely, that it was in every essential a fibroma, and in that it had two points of origin. This is rather unusual.

The question arises, whether a case of this sort ever gets well spontaneously. They are like fibroid tumors of the uterus in this regard. But, of course, one cannot act upon this belief, because these tumors render the individual in such a miserable condition that relief from them is worth seeking.

The diagnosis is usually so distinct that it can be made, as a rule, without examining the patient. We have the closure of the nares, the nasal intonation of the voice, and epistaxis, as cardinal symptoms. The point to be taken into consideration in a case of this kind, is the question of malignancy. The ordinary fibroma is probably not malignant, but there is a class of cases in which a diagnosis cannot be made between the fibroid tumor and sarcoma. The speaker then narrated a case of this character in which the growth extended into the antrum, elevated the orbital plate and produced legophthalmos. The tumor was removed, but it has returned, almost without doubt, by this time.

Now, if we cannot make a diagnosis before the removal, are we justified in using such snares as will remove only a part of the tumor, and in operating entirely in the dark? Are we justified in removing these things piece-meal, and trusting to luck that we have gotten away all of the growth? The speaker further expressed preference for a heavy piece of catgut in the snare instead of wire in these operations. Ordinarily, just at the most interesting moment of the operation, just as the tumor is expected to come away, the wire will break. He would not have the patience to sit for hours in front of his patient, turning a screw every half hour.

Other operations have been made, and the speaker thought that he would select one of the other operations. Long ago the soft palate was split for tumors of this kind, and he thought that in this case he would have split the soft palate. By splitting the nose,

not at the centre, but at the angle, a view of the interior of the nares can be obtained which cannot be excelled, and the resulting scar amounts to practically nothing at all. In these grave cases of fibroma, or in the graver cases of sarcoma, the more extensive operation that would be performed by the surgeon would have proved more radical than that which has been reported to-night.

DR. T. V. FITZPATRICK said that the only way of making a diagnosis in these cases would be by procuring a portion of the growth and examining it with the microscope. He could not agree with the last speaker in recommending one of the graver operations without first trying electrolysis. He thought this a case in which the general surgeon would do well to consult a specialist.

DR. ERIC SATTLER agreed with the last speaker, that the only way of making a diagnosis was by means of the microscope. Another point which he desired to emphasize was the fact that fibro-sarcoma of the nose is not so dangerous as sarcoma elsewhere. He thought that the fatality following a graver operation in these cases was much greater than that which would follow a milder operation. And what is of as much importance, patients will not consent to the serious operation as readily as they will to the less severe.

DR. FITZPATRICK asked whether there is any evidence that fibromata have ever degenerated into sarcomata.

DR. SATTLER replied that references are made in literature to the degeneration of one class of tumors into another, but that he could state nothing positive about the occurrence.

DR. RANSOHOFF stated that the microscope might help us or it might not help us in the diagnosis of these tumors. He did not think that a positive diagnosis could be made until the whole tumor had been removed. The chances are that the changes resulting from the action of the air on the surface of the growth, or by any other irritant, will be sufficient to render obscure the diagnosis.

As to the possibility of a benign

tumor becoming malignant, the speaker had no doubt. That a fibroma may undergo malignant degeneration into a sarcoma, he had not the least doubt. He knew that fibromata of the upper maxilla, after remaining for years innocuous, will undergo transformation into sarcomata.

He further disclaimed any intention of saying that in every case of tumors of the naso-pharynx he would split open the nose. He had said that rather than to remove the growth piece-meal, he would certainly split the soft palate or the nose, so as to get into the cavity. He did not see why any case should die from hemorrhage. You can plug the anterior and posterior nares so easily that fatal hemorrhage cannot occur.

DR. RICKETTS in conclusion, and referring to the use of the catgut instead of wire in the snare, said that he did not think that in the case he had reported, it would be possible to get the catgut around the growth. The tumor was strawberry-shaped, and the wire was with great difficulty gotten around it. The patient had never been operated upon previous to this time. The only case the speaker had found reported similar to this one, having both forms of tumor associated, was one operated upon in 1888 by Dr. Walden of Birmingham.

137 Broadway.

